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Patient Safety and Clinical Risk Management for General Practice

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Abstract

General practitioners are the first contact between the person, the family and the community with the health system. The philosopher and epistemologist K. Popper (1902-1994) recommended the need to register errors, in order to know them, catalog them and therefore prevent them. J.Reason in 1963 introduced the systemic approach to the study of errors with the theory of latent errors. The knowledge of the causal factors, or which in any case contribute, of possible errors, as well as of the latent gaps in the system, is a fundamental prerequisite for the construction of paths aimed at improving the quality of assistance, structures and organizational aspects.

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Introduction

General practitioners are the first contact between the person, the family and the community with the health system. Therefore they represent an important reference for choices related to health services, such as education in healthy lifestyles and for the adoption of appropriate behaviors in situations of illness and rehabilitation.

It is considered necessary by general practitioners to promote the improvement of the quality and safety of care in every area. In this way it will be possible to reduce the risk of incurring damages resulting from the treatment, thus also being able to optimize the available resources.

Patient safety must be promoted, by adopting appropriate methodologies and tools in one's professional practice, but also by promoting adequate information for users in order of conscious participation and for the use of services in other areas such as prevention, treatment and rehabilitation.

Risk Management

In the management of healthcare services, risk management constitutes a branch of the complex tree that represents the "Clinical Governance" [1].

The philosopher and epistemologist K. Popper (1902-1994) recommended the need to register errors, in order to know them, catalog them and therefore prevent them, when saying*: "all scientific knowledge is hypothetical and conjectural; what we can call the method of science is to learn systematically from our mistakes in the first place daring to commit them and, secondly, systematically going in search of the mistakes we made. "* [2].

J.Reason in 1963 introduced the systemic approach to the study of errors with the theory of latent errors. According to this theory, the occurrence of an accident is the result of a chain of events that occurred despite the barriers that had been put in place [3].

In recent years, much knowledge on clinical risk management has been produced and spread to the international community. L. Leape for example [4] has synthesized what has been learned in health with regard to the patient's Security: systems theory works; frontline operators have the power to truly achieve safety objectives; the creation of a safe system is difficult because old habits die slowly; despite its recognized importance, the adoption of computerized systems for managing clinical documentation, in practice, is not obvious or simple; safety concerns relations between people and depends largely on the operating team; culture is the main factor and changes from reality to reality; must be created a culture responsible, not punitive and inappropriate behavior should not be tolerated.

In particular, it is necessary to: involve the patient; communicate the adverse event; measure and analyze the performance of doctors; publish data on adverse events. The ability to record, catalog and analyze adverse events and errors is essential in order to identify preventive solutions.

The commitment to the development of patient safety in primary medicine at an international level is aimed above all at the construction and implementation of reporting systems, precisely called "incident reporting" [5,6] for the recognition of risk factors and contributing factors in order to identify the most appropriate measures in the specific field, previously established methodology for aeronautical systems [7].

It should be noted, however, that the reference studies mainly dealt with adverse events and errors that occurred in the hospital environment, while those relating to territorial medicine are limited [8-10].

In the health sector, there are many factors that contribute to defining the "degree of risk" of the system. Two categories are proposed and analyzed here: human factors and external factors.

Human Factors

Competence

Competence is defined as the suitability to treat, judge and resolve certain issues and the ability to do so[11]. The World Health Organization (WHO) states that *"The competence requires knowledge, appropriate attitudes and observable mechanical or intellectual abilities that together contribute to the provision of a specific professional performance."* [12].

Training and updating are important to maintain adequate standards of competence of the doctor such as

to allow him to manage and solve the problems of the patients, according to the best available evidence, in a safety regime.

Communcation[13]

A central element for error prevention in medicine is good communication, in particular the doctor-patient communication and/or medical-informal careers (family members, other caregivers, volunteers) and doctor-doctor communications or doctor-other medical professionals.

The general practitioner defines for each patient a course of care which is managed in collaboration with the patient himself and/or with the informal caregivers.

The patient is exposed to clinical risk if not adequately carrying out certain tasks, as specified below: insufficient explanation and verification of understanding on how to take the drugs; lack of periodic verification of the correct taking procedures; lack of information on the interactions between drugs and between drugs and foods; lacking or insufficient periodic review of the patient's motivation and patient confidence in therapy; lack of communication with family members or informal caregivers if the patient is unable to cooperate; non-assessment of any intake of drugs not prescribed by the attending physician.

As mentioned, the patient should be assessed in an integrated manner through collaboration between general practitioners and other health professionals. Even communication with the pharmacist contributes to the reduction of medication errors and improving prescription appropriateness. In addition, the general practitioner must integrate with the community nurse and other medical specialists in home and access to the social worker.

Recording and Transmission of Data

The registration, archiving and updating of the health documentation data is particularly important; the medical record and the health documentation, that set of documents that record a heterogeneous complex of health, personal and social information, are very useful for preparing the appropriate health interventions and for carrying out statistical, scientific and medico-legal investigations. The computerization of medical records in primary care has also brought a significant advantage for a systematic and regular recording of active problems, clinical and instrumental data, the presence of familiarity, anthropometric data, and lifestyle habits [14].

The aspect of data transmission is equally fundamental, such as the transmission of clinical data from general practitioners to various specialists. Equally fundamental is the reporting of Adverse Drug Reactions (ADR), as the importance and danger of drug pathologies is still not sufficiently perceived by doctors and public opinion. These diseases have significant incidence, mortality, social and economic costs.

Organization, Integration and Establishment of a Team

In primary care, the Team is represented by all GPs, secretarial and nursing staff operating in a single office or in association[15]. The availability of secretarial staff is another necessary condition for the optimization of the work, because it allows the physician to focus on clinical problems and talk with patients. The secretarial staff, in fact, deals with the reception management in the waiting room and numerous phone calls coming in, putting an important filtering activities. It also allows you to organize ambulatory activity with a by appointment system that offers considerable advantages, such as reducing waiting times, the ability to devote to each patient an appropriate time, no clogging of the waiting room, the greatest silence and order in the doctor's office, so the factors involved in risk reduction are therefore allowed and the doctor will have more time for clinical activities, consultancy interventions, preventive medicine interventions and well-organized follow-up

Problems Related to Users

There are many patient behaviors that can constitute a latent gap and possibly induce the doctor to produce an error. For example, do not report to the attending physician when you are carrying out therapy prescribed by other doctors, or the onset of new symptoms or a clinical worsening, or even the suspension or modification of the drug therapy in progress, or the intake of a new drug without first consulting your doctor.

External Factors

Often the error in medicine is facilitated or induced by external factors, which therefore do not

directly concern the competence, organization, communication skills of the doctor and the collaboration of the patient and informal careers.

System Functional Specifications

In addition to clinical activities, the work of the general practitioner also includes bureaucratic/ administrative activities such as certification, illness, accident, insurance and death, and a significant amount and variety of other certifications and certificates (for example of general physical fitness, of good health) is currently required, with exasperation of the workload. Certificates or requests for ambulance transport must be drawn up, for the home activation of the visit, for the recognition of civil invalidity, for the delegation to collect the pension, for access by car to restricted traffic areas. The support of a good program for the computerized management of the medical record and the help of the office staff are the optimal solution to not take time away from the assistance activity.

Structural and Technological Features

Further possible causes of error are represented by the structural characteristics of the medical office, by its equipment in terms of supports and accessories and by the technological characteristics of any medical equipment used. Some examples: inadequate medical office facility for amplitude, air conditioning, soundproofing; use of material for dressing with no guarantee of sterility; use of non-compliant instrumentation and without adequate maintenance; use of equipment without adequate skills; lack of containers for the collection of special medical waste at infectious risk.

Mass Media Conditioning [16]

The professional competence of the doctor must be the result of scientific, specific and continuous training. As any commercial interests can distort some types of messages and information, everything that comes from different fields (industry, mass media) can be valid and reliable, but must always be properly assessed and filtered.

The patient and/or informal caregivers can be influenced either by third parties (friends and acquaintances who provide advice on managing health problems) or by mass media that provide misleading models and messages. Messages can be the cause of error, especially when they suggest self-medications for some clinical problems that should be managed by the doctor, or when they propose paths that guarantee immediate and effortless "results" with a great deal of health information, often not adequately filtered and sometimes containing misleading and potentially harmful messages, such as in proposing slimming diets, perhaps with the use of drugs. All this requires the general practitioner to monitor and enhance the educational messages towards their patients, with the aim, not at all simple, correct any misinformation.

Conclusion

The knowledge of the causal factors, or which in any case contribute, of possible errors, as well as of the latent gaps in the system, is a fundamental prerequisite for the construction of paths aimed at improving the quality of assistance, structures and organizational aspects. The measures aimed at the prevention of errors and adverse events must be proposed to all healthcare professionals: for their identification, however, awareness of the role of causative or contributing factors cannot be ignored, as well as an error detection system that allows carry out investigations from which to extract useful information to implement patient safety.

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